MEASUREMENTS AND OTHER FINDINGS

51 HEIGHT	52 WEIGHT	53 COLOR HAIR	54 COLOR EYES	55 BUILD	56 TEMPERATURE
5' 11"	207	Black	Brown	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	98.6

57 BLOOD PRESSURE (Arm at heart level)						58 PULSE (Arm at heart level)			
A SITTING	SYS / DIAS	B RECUMBENT	SYS / DIAS	C STANDING (5 min.)	SYS / DIAS	A SITTING 70	B AFTER EXERCISE	C 2 MIN. AFTER	D RECUMBENT	E AFTER STANDING 3 MIN.

59 DISTANT VISION		60 REFRACTION			61 NEAR VISION	
RIGHT 20/	CORR TO 20	BY	S	C>	CORR TO	BY
LEFT 20/	CORR TO 20	BY	S	C>	CORR TO	BY

62 HETEROPHORIA (Specify distance)

ES°	EX°	R H	L H	PRISM DIV	PRISM CONV CT	PC	PD

63. ACCOMMODATION		64. COLOR VISION (Test used and result)	65 DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT	LEFT	Ishihara		CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (Test used and score)	68 RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING			71 AUDIOMETER									72 PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)
RIGHT WV	/15 SV	/15		250 255	500 512	1000 1024	2000 2048	3000 2895	4000 4096	6000 6144	8000 8192	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

73 NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

HOSP None PSY HX None

ALLERGY None PMH None

DRUG HX None PSH None

MEDICATION None ALCOHOL HX None

OTHER: specify None
(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

eye healthy male

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

None

77. EXAMINEE (Check)

A. ☒ IS QUALIFIED FOR general assignment

B. ☐ IS NOT QUALIFIED FOR

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

B. PHYSICAL CATEGORY

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN ROBERT TASSINARI PHYSICIAN ASSISTANT M.C.C., NEW YORK — SIGNATURE

80. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which) MARK A. GLOVER M.D. CLINICAL DIRECTOR MCC - NEW YORK — SIGNATURE

82. TYPED OR PRINTED NAME OR REVIEWING OFFICER OR APPROVING AUTHORITY — SIGNATURE — NUMBER OF ATTACHED SHEETS

☆U.S. Government Printing Office: 1989-262-081/90235

REPORT OF MEDICAL EXAMINATION

1. LAST NAME–FIRST NAME–MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ALLEN, A.	4	404-28-053

4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
M	B			DOJ	BOP

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
5-2-64		

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
FMC-FTW	

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
	18. HEAD, FACE, NECK AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS–GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71)	
	23. DRUMS (Perforation)	
	24. EYES–GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements nystagmus)	
	28. LUNGS AND CHEST (Include breasts)	
	29. HEART (Thrust, size, rhythm, sounds)	
	30. VASCULAR SYSTEM (Varicosities,etc.)	
	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Prostate, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

	Restorable Teeth	Non-restorable teeth	Missing Teeth	Replaced by Dentures	Fixed Partial dentures
Examples	0 / 1 2 3 / 32 31 30 / 0	/ / 1 2 3 / 32 31 30 / /	x / 1 2 3 / 32 31 30 / x	x x x / 1 2 3 / 32 31 30 / x x x	(x) / 1 2 3 / 32 31 30 / (x)

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

5 YR FITNESS EXAM WK

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY	46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN / D. MICROSCOPIC	
C. SUGAR	

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD	56. TEMPERATURE
73 11"	215 LBS	BLACK	Brown	☐ SLENDER ☑ MEDIUM ☐ HEAVY ☐ OBESE	97

57. BLOOD PRESSURE (Arm at heart level): A. SITTING SYS 146 DIAS 84; B. RECUMBENT SYS DIAS; C. STANDING (5 min.) SYS DIAS

58. PULSE (Arm at heart level): A. SITTING 96 R; B. AFTER EXERCISE; C. 2 MIN. AFTER; D. RECUMBENT; E. AFTER STANDING 3 MIN.

59. DISTANT VISION: RIGHT 20/ CORR. TO 20/; LEFT 20/ CORR. TO 20/

60. REFRACTION: BY S CX; BY S CX

61. NEAR VISION: CORR. TO BY; CORR. TO BY

62. HETEROPHORIA (Specify distance): ES° EX° R.H. L.H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION: RIGHT LEFT

64. COLOR VISION (Test used and result)

65. DEPTH PERCEPTION (Test used and score): UNCORRECTED / CORRECTED

66. FIELD OF VISION

67. NIGHT VISION (Test used and score)

68. RED LENS TEST

69. INTRAOCULAR TENSION

70. HEARING: RIGHT WV /15 SV /15; LEFT WV /15 SV /15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT								
LEFT								

72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

⊕ JD 1984
ON HEPATITIS
c̄ SUBSTANCE ABUSE
OTB
NKA

① HTN X 6 MOS Rx c̄ CATAPRES 0.1 MG BID
② ⊕ PPD 1993 Rx c̄ INH COMPLETED THEN (1993

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

① HTN
② ⊕ PPD (Rx COMPLETED 1993)
③ JD 1984

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

MAINTAIN PRESENT Rx REGIME

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (Check)
A. ☑ IS QUALIFIED FOR REG DUTY
B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

A ✓	B	C	E

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79. TYPED OR PRINTED NAME OF PHYSICIAN: J. GUARNERI, PA. — SIGNATURE: [signature]

80. TYPED OR PRINTED NAME OF PHYSICIAN: B. EZAZ, M.D. — SIGNATURE: B. EZAZ MD

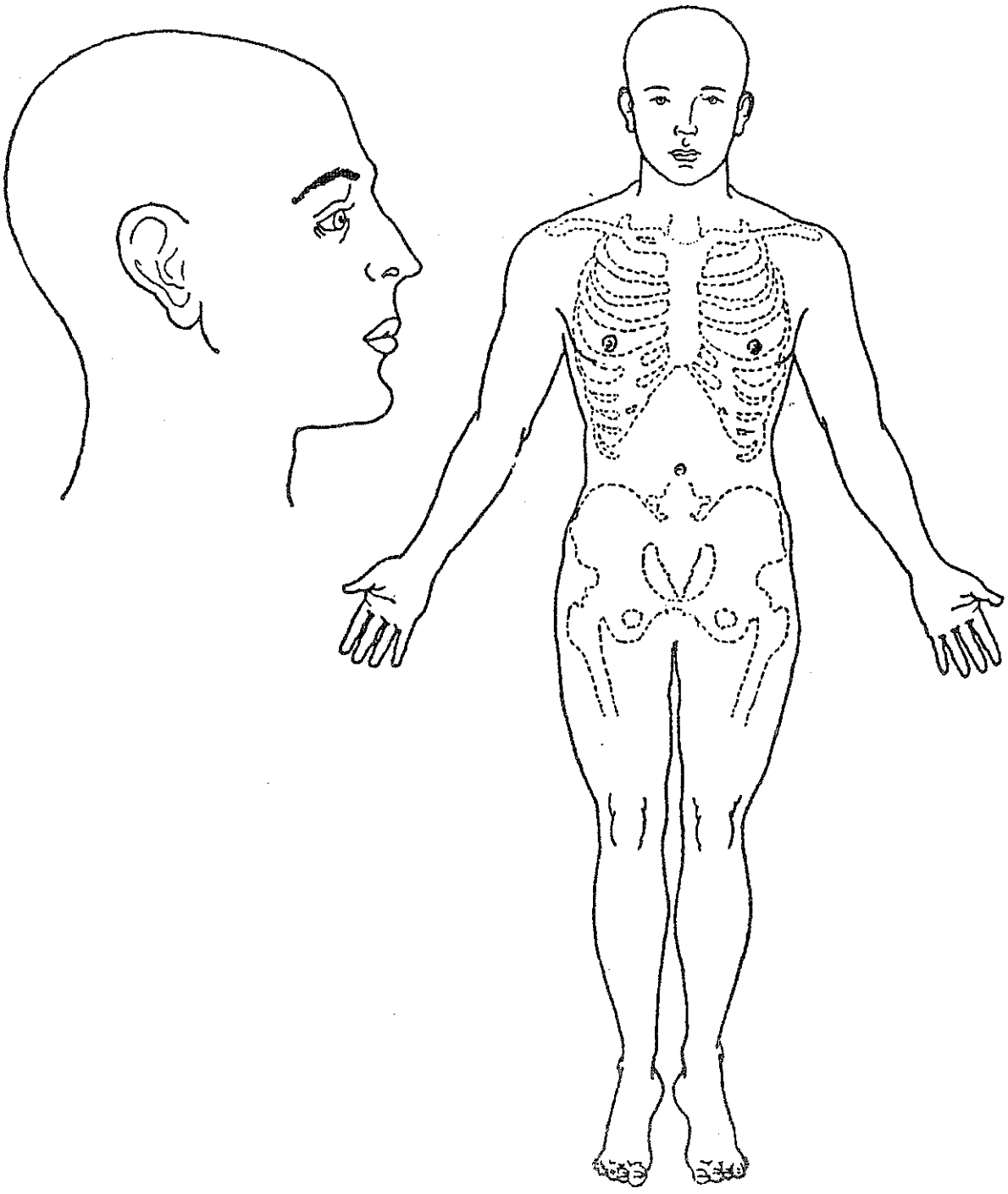
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which): BRENDA BURGES, D.D.S. — SIGNATURE: Brenda J. Burges DDS

82. TYPED OR PRINTED NAME OR REVIEWING OFFICER OR APPROVING AUTHORITY — SIGNATURE — NUMBER OF ATTACHED SHEETS

531-110

NSN 7540-00-634-4274

MEDICAL RECORD | **ANATOMICAL FIGURE**



PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility.)*

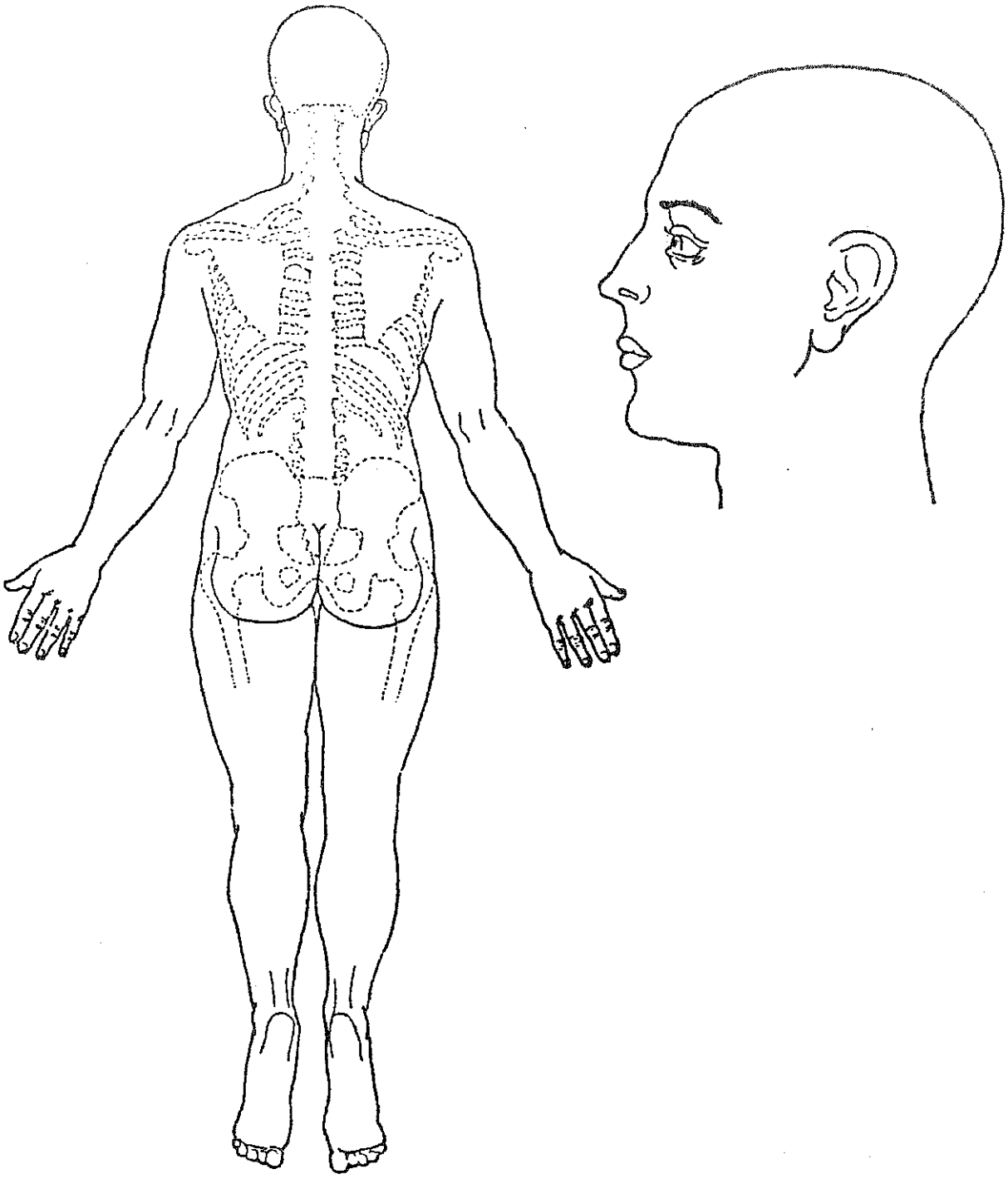
REGISTER NO. 40428.053

WARD NO.

Allen, Anthony

ANATOMICAL FIGURE

STANDARD FORM 531 (Rev. 4-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1



*U.S. Government Printing Office: 1992 — 312-071/50064

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

Allen, J

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
Allen, James J.	47[illegible]

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
INTAKE SCREEN	8-25-94	FCI [illegible] HEALTH SERVICES

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

HTN - 7 mos.
Med - Clonidine 0.1 BID
"use to have headaches but none for a couple mos"
"Does not need pain med"

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	/	Lived with anyone who had tuberculosis
	/	Coughed up blood
	/	Bled excessively after injury or tooth extraction
	/	Attempted suicide
	/	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	/	Wear glasses or contact lenses
/		Have vision in both eyes
	/	Wear a hearing aid
	/	Stutter or stammer habitually
	/	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	/		Scarlet fever		/		Adverse reaction to serum drug		/		Epilepsy or fits
	/		Rheumatic fever		/		or medicine		/		Car, train, sea or air sickness
	/		Swollen or painful joints		/		Broken bones		/		Frequent trouble sleeping
	/		Frequent or severe headache		/		Tumor, growth, cyst, cancer		/		Depression or excessive worry
	/		Dizziness or fainting spells		/		Rupture/hernia		/		Loss of memory or amnesia
		/	Eye trouble - WHEN I READ		/		Piles or rectal disease		/		Nervous trouble of any sort
	/		Ear, nose, or throat trouble		/		Frequent or painful urination		/		Periods of unconsciousness
			Hearing loss		/		Bed wetting since age 12				Have you ever had
			Chronic or frequent colds		/		Kidney stone or blood in urine		/		homosexual contact?
	/		Severe tooth or gum trouble		/		Sugar or albumin in urine		/		Been exposed to AIDS
	/		Sinusitis		/		VD—Syphilis, gonorrhea, etc.		/		Alcohol Use (Excessive)
	/		Hay Fever		/		Recent gain or loss of weight		/		Drug Use/Addiction
	/		Head injury		/		Arthritis, Rheumatism, or Bursitis		/		Marijuana
	/		Skin diseases		/		Bone, joint or other deformity		/		Cocaine
	/		Thyroid trouble		/		Lameness		/		Heroin
	/		Tuberculosis		/		Loss of finger or toe		/		L.S.D.
	/		Asthma		/		Painful or "Trick"shoulder or elbow		/		Amphetamines
	/		Shortness of breath		/		Recurrent back pain		/		Others: (Specify)
	/		Pain or pressure in chest		/		"Trick" or locked knee				
	/		Chronic cough		/		Foot trouble				Alcohol or drug
	/		Palpitation or pounding heart		/		Neuritis		/		Withdrawal Problems
	/		Heart trouble		/		Paralysis (include infantile)				
	/		High or low blood pressure ON MED SEE ABOVE		/						
	/		Cramps in your legs								
	/		Frequent indigestion								
	/		Stomach, liver, or intestinal trouble								
	/		Gall bladder trouble or gallstones								
	/		Jaundice or hepatitis								

10. FEMALES ONLY HAVE YOU EVER

		Been treated for a female disorder
		Had a change in menstrual pattern
		ARE YOU PREGNANT
		SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

Construction

12. ARE YOU (Check one)

☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	1	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		1	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	1	B. Inability to perform certain motions.		1	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	1	C. Inability to assume certain positions.			
	1	D. Other medical reasons *(If yes, give reasons.)*		1	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	1	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
	1	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		1	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	1	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	1	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		1	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13-22 ABOVE)

DO YOU HAVE

Frequent Colds	X No	___ Yes
Thrush	X No	___ Yes
Night Sweats	X No	___ Yes
Diarrhea	X No	___ Yes
Skin Rashes	X No	___ Yes

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: ALLEN, ANTHONY

SIGNATURE: Anthony Allen

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ___ TRANSFER ___ P.V. ___

OTHER ___

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED, WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ___

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO X

WHAT ARRANGEMENTS HAVE BEEN MADE? ___

DUTY STATUS: TEMPORARY WORK ___ RESTRICTED ___

GENERAL POPULATION ___ YES ___ NO ___

TYPE AND EXTENT OF LIMITATION ___

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

HTN

Medications	___ No	✓ Yes for HTN
Allergies	X No	___ Yes
Medical Complaints	X No	___ Yes
[illegible]	X No	___ Yes
[illegible]	X No	___ Yes
Suicidal thoughts	X No	___ Yes

Medications: Clonidine for HTN
Allergies:
Alcohol/drug/tobacco use:
Serious illness/operations:
Venereal disease/homosexuality:
Hx hepatitis:
Significant family hx:

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
A F GUNTHER M D	8-25-94		

REVERSE

(THIS INFORMATION IS FOR OFFICIAL AND MEDICAL CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME-FIRST NAME-MIDDLE NAME	2. REGISTER NUMBER
[illegible]	40428-053
3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION: 12/15/03
	5. EXAMINATION FACILITY

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATION CURRENTLY USED (Follow by description of past history, if complaint arises)

N/A

7. HAVE YOU EVER (Please check each item)			8. DO YOU (Please check each item)		
YES	NO	(Check each item)	YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis			Wear glasses or contacts lens
	✓	Cough up blood			Have vision in both eyes
	✓	Bled excessively after injury or tooth extraction		✓	Wear hearing aid
		Attempted suicide		✓	Stutter or stammer habitually
	✓	Been a sleepwalker		✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever				Adverse reaction to		✓		Epilepsy or fits
	✓		Rheumatic fever				drug or medicine		✓		Car, train, sea or air sickness
			Swollen or painful		✓		Broken bones		✓		Frequent trouble sleeping
	✓		joints		✓		Tumors, growth, cyst, cancer		✓		Depression or excessive worry
	✓		Frequent or severe	✓			Rupture/hernia		✓		Loss of memory or amnesia
	✓		headache		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Dizziness or fainting		✓		Frequent or		✓		Periods of unconsciousness
			spells		✓		painful urination		✓		Have you ever had
	✓		Eye trouble		✓		Bed wetting since age 12		✓		homosexual contact?
	✓		Ear, nose, throat trouble		✓		Kidney stone or		✓		Been exposed to AIDS
	✓		Hearing loss				blood in urine		✓		Alcohol Use (Excessive)
	✓		Chronic, frequent colds				Sugar, albumin in urine		✓		Drug Use/Addiction
	✓		Severe tooth, gum trouble				VD-Syphilis, gonorrhea,		✓		Marijuana
	✓		Sinusitis				etc.		✓		Cocaine
	✓		Hay Fever				Recent gain or loss of		✓		Heroin
			Head injury				weight		✓		L.S.D.
	✓		Skin disease				Arthritis, Rheumatism,		✓		Amphetamines
			Thyroid trouble				or Bursitis				Others: (Specify)
			Tuberculosis				Bone, joint or				
			Asthma				other deformity				Alcohol or drug
	✓		Shortness of breath				Lameness		✓		Withdrawal Problems
			Pain, pressure in chest				Loss of finger or toe				

This form may be replicated via WP)

This form replaces BP-360(60) dated January 1986

FTCOKL-01

			Chronic cough				Painful or "trick"				
			Palpitation or pounding				shoulder or elbow	10. FEMALES ONLY HAVE YOU EVER			
			heart				Recurrent back pain				Been treated for a
			Heart trouble				"Trick" or locked				female disorder
			High or Low blood				Foot trouble				Had a change in
			pressure				Neuritis				Menstrual pattern
			Cramps in your legs				Paralysis (include				ARE YOU PREGNANT
			Frequent indigestion				infantile)				SUSPECT YOU ARE
			Stomach, liver, or				Gall bladder trouble				PREGNANT
			intestinal trouble				or gallstones				
			Jaundice or hepatitis								

11. WHAT IS YOUR OCCUPATION?

12. ARE YOU (check one) ☑ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
		13. Have you been refused employment or bee unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury notes? (If yes, specify when, where, and give details.)
		B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
		C. Inability to assume certain positions.			
		D. Other medical reasons (If you, give reasons.)			
		14. Have you, ever been treated for mental condition? (If yes, specify when, where, and give details.)			20. Have you ever been rejected for military service because of physical, mental or other reason? (If yes, give date, and reason for rejections>)
		15. Have you ever been denied life insurance? Reason give details.)			21. Have your ever been discharged from military service because of physical mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)
		16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)			22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, what amount, when, why.)
		17. Have you ever been a patient in any type of hospital? (If yes, specify when, where why, and name of doctor and complete address of hospital.)			

I certify that I have reviewed the forgoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of my doctors, hospitals, or clinics mentioned above to furnish the government a complete transcript of my medical record.

TYPED OR PRINTED NAME OR EXAMINEE | SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT_____TRANSFER _____P.V._____

OTHER _____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG HOW MUCH, HOW OFTEN HOW USED. WHEN WERE THEY LAST USED:

HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? _____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES _____ NO _____

WHAT ARRANGEMENTS HAVE BEEN MADE? _____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED _____

GENERAL POPULATION _____ YES _____ NO _____

TYPE EXTENT OF LIMITATION _____

23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

TYPE OR PRINT NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Federal Transfer Center, OK			

Food or Drug Allergies: NKA: Allergies: _____

Current Medical Status: No Complaints: Complaint of _____

TB Signs and Symptom(s): None: Cough, hemoptysis, night sweats, wt. loss

U.S. Department of Justice

Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
[illegible]	[illegible]

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Screening	8/22/94	USP Lewisburg Health Services Unit Lewisburg, PA 17837

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

[illegible] medical concerns

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
	✓	Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to serum drug		✓		Epilepsy or fits
	✓		Rheumatic fever				or medicine		✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones		✓		Frequent trouble sleeping
	✓		Frequent or severe headache		✓		Tumor, growth, cyst, cancer		✓		Depression or excessive worry
	✓		Dizziness or fainting spells		✓		Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12		✓		Have you ever had
	✓		Chronic or frequent colds		✓		Kidney stone or blood in urine				homosexual contact?
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
	✓		Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight		✓		Drug Use/Addiction
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis		✓		Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity		✓		Cocaine
	✓		Thyroid trouble		✓		Lameness		✓		Heroin
	✓		Tuberculosis		✓		Loss of finger or toe		✓		L.S.D.
	✓		Asthma		✓		Painful or "Trick"shoulder or elbow		✓		Amphetamines
	✓		Shortness of breath		✓		Recurrent back pain		✓		Others: (Specify)
	✓		Pain or pressure in chest		✓		"Trick" or locked knee		✓		
	✓		Chronic cough		✓		Foot trouble		✓		Alcohol or drug
	✓		Palpitation or pounding heart		✓		Neuritis		✓		Withdrawal Problems
	✓		Heart trouble		✓		Paralysis (include infantile)		✓		
	✓		High or low blood pressure		✓				✓		
	✓		Cramps in your legs		✓			10. FEMALES ONLY HAVE YOU EVER			
	✓		Frequent indigestion		✓				✓		Been treated for a female disorder
	✓		Stomach, liver, or intestinal trouble		✓				✓		Had a change in menstrual pattern
	✓		Gall bladder trouble or gallstones		✓				✓		ARE YOU PREGNANT
	✓		Jaundice or hepatitis		✓				✓		SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)

☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
		C. Inability to assume certain positions.			
	✓	D. Other medical reasons *(If yes, give reasons.)*			20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
		14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
		15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
		16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13–22 ABOVE)

No medical Care claim
H/x HTN

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ✓ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? NO

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? NONE

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ____

GENERAL POPULATION ____ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION NONE

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

Clonidine (Catapres) 0.1 mg
5x p.o. BID

Medications
Allergies
Medical Complaints
Presence of Lice
Drug Use
Rights

Yes ___ No
Yes ___ No
Yes ___ No
Yes ___ No
Yes ___ No
Yes ___ No

DO YOU HAVE

Frequent Colds — No ___ Yes
Thrush — No ___ Yes
Night Sweats — No ___ Yes
Diarrhea — No ___ Yes
Skin Rashes — No ___ Yes

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
ATUL CHOPRA EMG - PA	5/06/04	Luis Martinez-Duran Physician Assistant	

REVERSE

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
		Coughed up blood
		Bled excessively after injury or tooth extraction
		Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
		Wear glasses or contact lenses
		Have vision in both eyes
		Wear a hearing aid
		Stutter or stammer habitually
		Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever		✓		Adverse reaction to serum drug				Epilepsy or fits
	✓		Rheumatic fever		✓		or medicine				Car, train, sea or air sickness
		✓	Swollen or painful joints				Broken bones				Frequent trouble sleeping
	✓		Frequent or severe headache		✓		Tumor, growth, cyst, cancer				Depression or excessive worry
			Dizziness or fainting spells				Rupture/hernia				Loss of memory or amnesia
		✓	Eye trouble		✓		Piles or rectal disease				Nervous trouble of any sort
			Ear, nose, or throat trouble		✓		Frequent or painful urination				Periods of unconsciousness
			Hearing loss		✓		Bed wetting since age 12				Have you ever had
			Chronic or frequent colds				Kidney stone or blood in urine				homosexual contact?
			Severe tooth or gum trouble				Sugar or albumin in urine				Been exposed to AIDS
			Sinusitis				VD—Syphilis, gonorrhea, etc.				Alcohol Use (Excessive)
			Hay Fever				Recent gain or loss of weight				Drug Use/Addiction
			Head injury				Arthritis, Rheumatism, or Bursitis				Marijuana
			Skin diseases				Bone, joint or other deformity				Cocaine
			Thyroid trouble				Lameness				Heroin
			Tuberculosis				Loss of finger or toe				L.S.D.
			Asthma				Painful or "Trick"shoulder or elbow				Amphetamines
			Shortness of breath				Recurrent back pain				Others: (Specify)
			Pain or pressure in chest				"Trick" or locked knee				
			Chronic cough				Foot trouble				Alcohol or drug
			Palpitation or pounding heart				Neuritis				Withdrawal Problems
			Heart trouble				Paralysis (include infantile)				
			High or low blood pressure								
			Cramps in your legs								
			Frequent indigestion								
			Stomach, liver, or intestinal trouble								
			Gall bladder trouble or gallstones								
			Jaundice or hepatitis								

10. FEMALES ONLY HAVE YOU EVER

		Been treated for a female disorder
		Had a change in menstrual pattern
		ARE YOU PREGNANT
		SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)
☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	/	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		/	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	/	B. Inability to perform certain motions.		/	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	/	C. Inability to assume certain positions.			
	/	D. Other medical reasons *(If yes, give reasons.)*		/	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	/	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		/	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	/	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
	/	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*		/	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	/	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13–22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ____

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ____

GENERAL POPULATION / YES ____ NO ____

TYPE AND EXTENT OF LIMITATION ____

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
PHYSICIAN FEDERAL CORRECTIONAL INST. EL RENO, OKLAHOMA	AUG 12 1994		

REVERSE

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER	
Allen Anthony G	40428-053	
3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Safe Ke Screen	6-10-94	FMC - Ft Worth

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

Cafergot b.i.d. prn (?)

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever				Adverse reaction to serum drug		✓		Epilepsy or fits
			Rheumatic fever				or medicine		✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones			✓	Frequent trouble sleeping
			Frequent or severe headache		✓		Tumor, growth, cyst, cancer			✓	Depression or excessive worry
✓			Dizziness or fainting spells			✓	Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12		✓		Have you ever had
✓			Chronic or frequent colds		✓		Kidney stone or blood in urine				homosexual contact?
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
			Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight		✓		Drug Use/Addiction
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis		✓		Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity		✓		Cocaine
		✓	Thyroid trouble			✓	Lameness		✓		Heroin
		✓	Tuberculosis		✓	✓	Loss of finger or toe		✓		L.S.D.
		✓	Asthma			✓	Painful or "Trick"shoulder or elbow		✓		Amphetamines
	✓		Shortness of breath			✓	Recurrent back pain				Others: (Specify)
	✓		Pain or pressure in chest		✓		"Trick" or locked knee				
	✓		Chronic cough		✓		Foot trouble				Alcohol or drug
	✓		Palpitation or pounding heart		✓		Neuritis		✓		Withdrawal Problems
	✓		Heart trouble		✓		Paralysis (include infantile)				
✓			High or low blood pressure								
		✓	Cramps in your legs					10. FEMALES ONLY HAVE YOU EVER			
		✓	Frequent indigestion								Been treated for a female disorder
✓	✓		Stomach, liver, or intestinal trouble								Had a change in menstrual pattern
✓	✓		Gall bladder trouble or gallstones								ARE YOU PREGNANT
✓	✓		Jaundice or hepatitis								SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR ~~USUAL OCCU~~PATION?

PRIS

12. ARE YOU (Check one)

☑ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.			
	✓	D. Other medical reasons *(If yes, give reasons.)*		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	✓	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13-22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
	[signature]

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ________

OTHER N. C.

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ________

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? ________

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED Pending

GENERAL POPULATION ✓ YES ____ NO

TYPE AND EXTENT OF LIMITATION Pending

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

1 - NICVA
2 - Operation - NO
3 - Fx - NO
4 - Hep - NO
5 - Drugs - NO
6 - Seizure - NO
7 - Drink - Social
8 - STD - NO
9 - No LA
10 - Hx HTN

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Kafato, E.F. PA.	6-10-94	E. F. [signature]	

REVERSE

STANDARD FORM 93
REV. OCTOBER 1974
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505

APPROVED
OFFICE OF MANAGEMENT AND BUDGET No. 29- R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. SOCIAL SECURITY OR IDENTIFICATION NO.
3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)	4. POSITION (title, grade, component)
299 [illegible] Ave Apt 11 [illegible]	Non
5. PURPOSE OF EXAMINATION: Enrolled Reserve	6. DATE OF EXAMINATION: 16 Oct 92
7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code): 0480 - NEW YORK HEALTH SERVICES UNIT 150 PARK ROW NEW YORK, NEW YORK 10007	

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history if complaint exists)

I am in good health
NO medication

9. HAVE YOU EVER (Please check each item)			10. DO YOU (Please check each item)		
YES	NO	(Check each item)	YES	NO	(Check each item)
		Lived with anyone who had tuberculosis			Wear glasses or contact lenses
		Coughed up blood			Have vision in both eyes
		Bled excessively after injury or tooth extraction			Wear a hearing aid
		Attempted suicide			Stutter or stammer habitually
		Been a sleepwalker			Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever, erysipelas				Cramps in your legs				"Trick" or locked knee
			Rheumatic fever				Frequent indigestion				Foot trouble
			Swollen or painful joints				Stomach, liver, or intestinal trouble				Neuritis
			Frequent or severe headache				Gall bladder trouble or gallstones				Paralysis (include infantile)
			Dizziness or fainting spells				Jaundice or hepatitis				Epilepsy or fits
			Eye trouble				Adverse reaction to serum, drug, or medicine				Car, train, sea or air sickness
			Ear, nose, or throat trouble								Frequent trouble sleeping
			Hearing loss				Broken bones				Depression or excessive worry
			Chronic or frequent colds				Tumor, growth, cyst, cancer				Loss of memory or amnesia
			Severe tooth or gum trouble				Rupture/hernia				Nervous trouble of any sort
			Sinusitis				Piles or rectal disease				Periods of unconsciousness
			Hay Fever				Frequent or painful urination				
			Head injury				Bed wetting since age 12				
			Skin diseases				Kidney stone or blood in urine				
			Thyroid trouble				Sugar or albumin in urine				
			Tuberculosis				VD—Syphilis, gonorrhea, etc.				
			Asthma				Recent gain or loss of weight				
			Shortness of breath				Arthritis, Rheumatism, or Bursitis				
			Pain or pressure in chest				Bone, joint or other deformity				
			Chronic cough				Lameness				
			Palpitation or pounding heart				Loss of finger or toe	12. FEMALES ONLY: HAVE YOU EVER			
			Heart trouble				Painful or "trick" shoulder or elbow				Been treated for a female disorder
			High or low blood pressure				Recurrent back pain				Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?
Fr

14. ARE YOU (Check one)
☑ Right handed ☐ Left handed

93-103

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	✓	15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.
	✓	B. Inability to perform certain motions.
	✓	C. Inability to assume certain positions.
	✓	D. Other medical reasons (*If yes, give reasons.*)
	✓	16. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details.*)
	✓	17. Have you ever been denied life insurance? (*If yes, state reason and give details.*)
	✓	18. Have you had, or have you been advised to have, any operations? (*If yes, describe and give age at which occurred.*)
	✓	19. Have you ever been a patient in any type of hospitals? (*If yes, specify when, where, why, and name of doctor and complete address of hospital.*)
	✓	20. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details.*)
	✓	21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.*)
	✓	22. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.*)
	✓	23. Have you ever been discharged from military service because of physical, mental, or other reasons? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.*)
	✓	24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (*If yes, specify what kind, granted by whom, and what amount, when, why.*)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
	[signature]

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data (*Physician shall comment on all positive answers in Items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.*)

ers healthy male
& medication

ROBERT TASSINARI
PHYSICIAN ASSISTANT
M.C.C., NEW YORK

16 Oct 99 [signature]

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
ANTHONY [illegible]	15 Oct 99	[signature]	

REVERSE OF STANDARD FORM 93

☆U.S.GPO:1986-0-181-247/40193

U.S. MEDICAL CENTER FOR FEDERAL PRISONERS
SPRINGFIELD, MISSOURI

TRANSFER SUMMARY

ALLEN, Anthony
Reg. No. 40428-053
January 20, 2004
WARD: S03

REASON FOR ADMISSION: Right inguinal hernia.

SIGNIFICANT FINDINGS: This is a 39-year-old Jamaican male referred to the U.S. Medical Center for Federal Prisoners (USMCFP), Springfield, Missouri, from the Federal Correctional Institution (FCI), McKean, Pennsylvania, with a six to seven year history of a right inguinal hernia, which gradually has been getting larger and more problematic for the individual. He was consequently referred to USMCFP for evaluation and treatment.

History and physical examination dated December 23, 2003, gives a diagnosis of a right inguinal scrotal hernia; otherwise, essentially healthy male.

LABORATORY: Dated 12-29-03 gives a profile A of a BUN of 6 (7-22), and the remainder essentially within normal limits. CBC was within normal limits. Urinalysis was within normal limits. RPR was positive at 1:1, with an MHA-TP of being nonreactive. HIV status was negative.

TREATMENT RENDERED: Patient was evaluated by Consultant Surgeon, Dr. Brent Rotton, on December 23, 2003, and scheduled for a right inguinal hernia repair with plug and patch, which was carried out on January 9, 2004. Postoperatively, the patient did well. On final evaluation done January 20, 2004, staples were removed with the wound being well-healed and the patient instructed on postoperative care.

PROCEDURES: On January 9, 2004, right inguinal hernia repair.

CONDITION ON DISCHARGE: Improved.

FINAL DIAGNOSES:
1. Status post right inguinal hernia repair.
2. Positive RPR at 1:1 ratio, with MHA-TP negative.
3. Essentially healthy male.

MEDICATIONS: None.

Kevin J. Kelly, Certified Physician Assistant — January 20, 2004

ALLEN, Anthony — Reg. No. 40428-053

RECOMMENDATIONS (to include Instructions to Patient):

1. Patient was instructed to continue with limited weightlifting of approximately 10-15 pounds over the next 5 weeks.
2. Physical activity as tolerated.
3. Regular diet.
4. Follow-up care on a prn basis per local institution's medical policy.
5. Duty work status: weightlifting limitation of approximately 10-15 pounds for the next 5 weeks.
6. No special appliances needed.
7. Transfer per the usual custodial means.

Kevin J. Kelly, PA-C

Thomas E. Hare, D.O.
Staff Physician

KJK/TEH/jh
D: 01/20/04
T: 01/23/04

U. S. MEDICAL CENTER FOR FEDERAL PRISONERS
SPRINGFIELD, MISSOURI

INITIAL HISTORY / PHYSICAL ADMISSION DATA SHEET

Inmate Name: Allen, Anthony
Number: 40428-053 DOB: 5-12-64
Date: 12/15/03 Time: 1030

Institution: McKean BP149 Reviewed: ✓ N/A
Prior Medical Record Available: Yes ____ No ____
Prior NON-BOP Incarceration: Yes ____ No ✓

Have you had or now have?

Bleeding Disorder	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
Lung Disease	Yes	No
Seizure Disorder	Yes	No
Stroke	Yes	No
Thyroid Disease	Yes	No
Mental Illness	Yes	No
Suicide Attemt/Year ____	Yes	No
Currently Suicidal	Yes	No
Other	Yes	No

see below

Hx of Hepatitis	Yes	No
Liver Disease	Yes	No
HIV Test Date ____	Yes	No
Date ____ Results	Pos	Neg
Sexual Contact - Heterosexual	Yes	No
Sexual Contact - Homosexual	Yes	No
Hx Blood Transfusion	Yes	No
If Yes, what Year ____		
Hx STD's	Yes	No
Hx of TB Exposure (*circle one*)	Yes	No
Family Hx of TB	Yes	No
Results of last PPD 0 mm		
Date of Last PPD 9/3/3		
If POS, Treated	Months	

Recent Weight Loss	Yes	No
Fever	Yes	No
Chills/Night Sweats	Yes	No
Chest Pains/SOB/N&V	Yes	No
Difficulty Eating	Yes	No
Unusual Headaches	Yes	No
Urinary Tract Infection Symptoms	Yes	No
Fatigue	Yes	No

Last CXR	Date	No
Cough > 2 weeks	Yes	No
Coughed up Blood	Yes	No
Black / Bloody Stools	Yes	No
Unusual Skin Sores / Lesions	Yes	No
Hx of Smoking	Yes	No
#pks/day ____	#of Years	
Quit Smoking	Year	

MAJOR SURGERIES: ∅

Allergies to Medications or Foods NKA ✓ Yes ____ List ____
MEDICATIONS (*Side effects Reactions*) ____
FOODS (*Side Effects Reactions*) ____
Current Medications (*See A-Sheet Doctor's Orders*)

Height 6'1" Weight 196 B/P 143/90
Pulse 74 Respirations ____ Temp ____
Apparent Signs of Distress Yes* ____ No ✓
Restricted Mobility ____

STATUS: Medical ____ Surgical ✓
Psych ____ D&O ____ Forensic ____
Work Cadre ____
Holdover ____

Lice/Other Parasites: Yes ____ None Seen ✓
Acute Skin Sores/Lesions: Yes ____ None Seen ____
Religion NC Housing ____

Hx. Of Abuse/Neglect/Victimization: Yes* ____ No ✓
Hx. Of Substance/Alcohol Abuse: Yes* ____ No ✓
Type? ____ Date Last Used? ____

Are you Having Pain? Yes ____ No ✓
Location ____
Frequency ____
Intensity 0 2 4 6 8 10
Duration ____

Dx and comments: 39 y/o AA (M) ingrown hernia pull

Signature of PA/RN ____
Additional Comments* on Reverse Side

(*Note any Items Should have a Comment*) SHADED ITEMS PLACE PATIENT AT GREATER RISK DURING RESTRAINT; SUICIDE PRECAUTIONS OR SECLUSION

Health Record - White Central File - Yellow Infection Control - Pink

SPG-74
Revised
Mar 2002/jdd

U.S. MEDICAL CENTER FOR FEDERAL PRISONERS
SPRINGFIELD, MISSOURI

SURGICAL CONSULTATION

ALLEN, Anthony
Reg. No. 40428-053
December 23, 2003
WARD: S03

ATTENDING PHYSICIAN: Dr. Hare

The patient was examined and chart reviewed.

IMPRESSION: 1. Large right inguinal hernia, easily reducible, nonincarcerated.

RECOMMENDATIONS: Right inguinal herniorrhapy with Bard mesh place system. The risks and benefits were discussed with the patient to include bleeding, infection, abscess, injury to other cord structures which could possibly result in loss of the testicle, and hernia recurrence. Patient understands and agrees and is willing to proceed.

HISTORY: This is a black male who presents with a large right inguinal hernia that has been present for approximately six years. He denies any signs or symptoms of bowel obstruction. He moves his bowels without problems or difficulties. On examination today, there is a large right inguinal hernia. There is no hernia noted on the left. Testes are descended bilaterally and normal appearing male external genitalia.

For further past medical and surgical history, please refer to the chart as it was reviewed and essentially unchanged as well as the remainder of his physical examination. This will be scheduled.

Thank you for the referral.

D. Brent Rotton, D.O.
Consultant General Surgeon

DBR/eb
D: 12-23-03
T: 12-31-03

U.S. MEDICAL CENTER FOR FEDERAL PRISONERS
SPRINGFIELD, MISSOURI

HISTORY AND PHYSICAL

ALLEN, Anthony George
Reg. No. 40428-053
December 23, 2003
Ward: S03

Birthdate: 05/02/64
Admission Date: 12/18/03

HISTORY - PART I

CHIEF COMPLAINT: Right inguinal hernia.

HISTORY OF PRESENT ILLNESS: This is a 39-year-old Jamaican male referred to Springfield from FCI McKean, Pennsylvania, with a 6-7 year history of a right inguinal hernia which he states has been getting larger and getting worse. Patient is referred to Springfield for further evaluation and treatment.

REVIEW OF SYSTEMS

SURGICAL HISTORY: Denied.

MEDICAL ILLNESSES: Denied.

HISTORY OF INJURIES: Denied.

Patient is a nonsmoker. Denies alcohol or drug use.

CURRENT MEDICATIONS: None.

ALLERGIES: None.

Generally patient states his weight is stable. Denies any chronic HEENT complaints.

CARDIOVASCULAR: Denies any history of asthma, pneumonia, bronchitis, shortness of breath, chest pain, heart disease, or palpitations.

GASTROINTESTINAL: Denies any chronic nausea, vomiting, diarrhea, bloody stools, hepatitis, or history of gallbladder disease.

GENITOURINARY: Denies any history of STDs, hematuria, kidney stones.

MUSCULOSKELETAL: Denies any chronic muscle aches or lower back pain.

LYMPHATICS: Denies any chronic lymphadenopathy.

NEUROVASCULAR: Denies any chronic radicular symptoms.

PHYSICAL EXAMINATION

HEIGHT: 6'1"
WEIGHT: 196
TEMPERATURE: 97.5
PULSE: 80
BLOOD PRESSURE: 1445/90

EARS:	Canals and TMs are clear bilaterally.
EYES:	PERRLA, peripheral vision intact. Sclera and conjuctiva are clear.
NOSE:	patent bilaterally.
MOUTH:	Clear. Teeth in fair repair. Posterior pharynx is clear.
NECK:	Supple.
LUNGS:	Clear to auscultation.
CARDIOVASCULAR:	Heart is regular rate and rhythm without murmurs.
ABDOMEN:	Soft, flat, normal bowel sounds.
EXTREMITIES:	Grossly equal and symmetrical appearing with full range of motion.
GENITALIA:	Uncircumcised adult male. Testicles descended bilaterally. Large right inguinal scrotal hernia is noted which is partially reducible at this time.
RECTAL/PROSTATE:	Not examined at this time.
NEUROLOGICAL:	Cranial nerves II-XII grossly intact. DTRs 2+/4. No tremors noted.

IMPRESSION:

1. Right inguinal scrotal hernia.
2. Essentially healthy male.

PLAN:

1. Initiate appropriate medical care.
2. Refer to appropriate services as needed to include consultation with general surgeon for surgical repair.

Kevin J. Kelly, PA-C

Thomas E. Hare, D.O.
Staff Physician

KJK/TEH/ch D: 12/23/03 T: 12/24/03

Kevin J. Kelly, Certified Physician Assistant December 23, 2003

ALLEN, Anthony George Reg. No. 40428-053

FEDERAL BUREAU OF PRISONS
MCFP Springfield, MO

NURSING DISCHARGE SUMMARY

DATE: 11/2/04
WARD: SOU
PHYSICIAN: Dr. Hare
DIAGNOSIS: S.P RTH

DISCHARGED TO:
_____ BOP INSTITUTION
_____ STATE INSTITUTION
_____ COMMUNITY HOME
__X__ OUTPATIENT
_____ OTHER

FOLLOW-UP REFERRAL
_____ NONE NEEDED
_____ INSTITUTION P. A.
_____ CHRONIC CARE
_____ COMMUNITY
__X__ CLINIC APPOINTMENT 11/20/04

MOBILITY
__X__ AMBULATORY
_____ WHEELCHAIR
_____ WALKER / CRUTCHES
_____ CART / GURNEY
_____ RESTRICTIONS

ATIENT TEACHING

			OTHER		
EDICATION REGIME	YES __X__	NO _____		YES _____	NO _____
ROPER DIET	YES __X__	NO _____		YES _____	NO _____
LF-CARE	YES __X__	NO _____		YES _____	NO _____
OD/DRUG INTERACTION	YES __X__	NO _____		YES _____	NO _____

MEDICATIONS	DOSAGE	HOW OFTEN	Rx	SPECIAL INSTRUCTIONS
Tylenol #3	1-11	Three x a day		

T: Regular **SUPPLEMENTAL NOURISHMENTS** _____

N CONTROL: (circle one) IMPROVED (CONTROLLED/STABLE) NO CHANGE WORSENED

ATMENT / WOUND CARE: (e.g. RT, PT) _____

cknowledge that I have been instructed on the above and understand what I am to do following arge.

to Patien t: __X__ Yes _____ No Date: 11/2/04

Signatur e: Anthony Allen

Signatur e: DMClanahan RN

SSOGR APH

ALLEN, ANTHONY
40428-053
MCFP SPG MO
DOB 05-02-64

SPG-62
Revised
September 2002

U.S. MEDICAL CENTER FOR FEDERAL PRISONERS
SPRINGFIELD, MISSOURI

OPERATION REPORT

ALLEN, Anthony
Reg. No. 40428-053
January 9, 2004
WARD: S03

ATTENDING PHYSICIAN: Dr. Hare

PREOPERATIVE DIAGNOSIS: Right inguinal hernia.

POSTOPERATIVE DIAGNOSIS: Same.

OPERATION PERFORMED: Right inguinal herniorrhaphy with insertion of mesh plug and patch system. Estimated blood loss minimal. Complications none. Drains none.

SURGEON: Dr. D. Brent Rotton

ASSISTANT SURGEON: None

ANESTHESIA: General

SPECIMENS REMOVED: Right inguinal hernia sac

DATE OF OPERATION: 01-09-04

DESCRIPTION OF OPERATION: The patient was taken to the OR room and placed in the supine position. He was administered general anesthesia. He was prepped and draped in the usual sterile fashion. Oblique incision overlying internal ring was carried through the skin and subcutaneous tissue to the level of the external oblique fascia which was sharpened and excised parallel to his fibers and extended through the external ring. The underlying ilioinguinal nerve was identified and kept out of harms way. The cord structures were elevated with a Babcock and allowed for blunt distal dissection circumferentially which allowed for passage of a Penrose drain per appropriate countertraction. There was a large hernia sac identified on anterior and medial aspect of the cord. This was carefully separated from the chord structures. The vas deferens and testicular vessels were very densely adhered to the hernia sac, however these were freed and the hernia sac was dissected high to the level of preperitonal fat. It was ligated doubly with 0 Vicryl suture. Redundant hernia sac was excised. Large mesh plug was secured to the stump of the hernia sac and inverted into the internal ring and circumferentially secured in the usual manner with several interrupted sutures. Overlay patch was then tailored, placed in the floor of the canal, and keyholed around the cord structures. The tail secured with

one stitch and the tail was placed slightly in fascia plane of external oblique. The area was irrigated. Hemostasis was noted. The external oblique fascia was closed with a running suture of 0 Vicryl starting at the external ring. 0.25% Marcaine was injected subfascially and around the incision. Scarpa fascia was closed with a running suture of 3-0 Vicryl and the skin was closed with a skin stapling device. Patient tolerated the procedure well and was transported to the recovery room in stable and satisfactory condition.

D. Brent Rotton, D.O.
Consultant General Surgeon

DBR/eb
D: 01-09-04
T: 01-14-04